GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIFUNGALS, INJECTABLE PA SUMMARY

Preferred	Non-Preferred
Abelcet (amphotericin B lipid complex) Amphotericin B generic Eraxis (anidulafungin) Fluconazole injection generic* Micafungin generic	Ambisome (amphotericin B liposome) Cancidas (caspofungin) Rezzayo (rezafungin) Voriconazole injection generic

*preferred but requires PA

LENGTH OF AUTHORIZATION: Varies

NOTES:

- If injectable medication is being administered in a physician's office or clinic, then the medication just be billed through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program is located at www.mmis.georgia.gov.
- Fluconazole injection is preferred but requires prior authorization (PA).

PA CRITERIA:

Fluconazole Injection Generic

- ❖ Medication must be administered in member's home or in a long-term care facility.

Ambisome

- ❖ Approvable for members who have been started on the medication as continuation of therapy.
- ❖ Approvable for members with a diagnosis of visceral leishmaniasis (VL).
- ❖ For members with other diagnosis, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Abelcet, is not appropriate for the member.

Cancidas

- ❖ Approvable for members who have been started on the medication as continuation of therapy.
- ❖ Approvable for members who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with two preferred products, one of which must be Eraxis or micafungin (Mycamine)?

Rezzayo

- ❖ Approvable for members who have been started on the medication as continuation of therapy.
- ❖ Approvable for members with a diagnosis of candidemia and invasive candidiasis who have limited or no alternative treatment options.

Voriconazole Injection Generic

- ❖ Approvable for members who have been started on the medication as a continuation of therapy.
- ❖ Approvable for members who have tried one other systemic antifungal agent and who have one of the following diagnoses:
    - Esophageal candidiasis
    - Candidemia in nonneutropenic patient
    - Disseminated Candida skin infection
    - Candida infection in abdomen, kidney, bladder wall or wound
- ❖ Approvable for members with invasive or pulmonary aspergillosis, fungal infection caused by Scedosporium apiospermum or fungal infection caused by Fusarium species.
- ❖ Approvable for prophylaxis of aspergillosis, candidiasis or invasive fungal infection in severely immunocompromised patients.
- ❖ Approvable for members with central nervous system (CNS) blastomycosis who have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect to itraconazole (Sporanox).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.